Society for Endocrinology

# Peer Review in Endocrinology

## Networked Reviews

## Self-Assessment Questionnaire

Centre to be visited……..

Visit date……

CC-2022-34c

**Introduction**

The need for Peer Review of UK endocrine units was agreed by the Clinical Committee of the Society for Endocrinology in 2001. The service is relevant to the agendas of clinical governance in endocrinology, and ensuring good quality universal care across the UK for patients.

Peer Review presents an opportunity to improve patient care, support and facilitate service provision and innovation. The process for peer review was revisited in 2017 and updated to include single centre reviews, patient feedback and dashboard data.

Since Covid-19 (2020) there has been significant changes to the way we work and peer review has changed to reflect this. In addition, rather than focus on tertiary centres, the Peer review process will encompass more explicitly secondary care centres, and also focus on networking and multidisciplinary services. It will give all centres an opportunity to discuss common themes and find mutually helpful solutions.

**Purpose**

The main purpose is to improve services for patients with endocrine diagnoses, modernise and benchmark against similar centres. Visits focus on basic standards of endocrine care and service provision. Visits form the basis for an exchange of ideas and experiences and allow areas of concern to be voiced.

**Structure**

Visits are made over three hours virtually normally by two consultant endocrinologists and two specialist endocrine nurses from different areas of the UK. Senior trainees or other allied health professionals may be part of the team. A separate document (*'Planning a PR Networked Visit'*) contains recommended structure for a visit but the SAQ will form the basis of discussion. Following the initial meeting there will be an afternoon networking event where challenges and innovations are discussed to help streamline services and gain from mutual expertise. A wider group from each centre will be invited to participate in this event.

**Visit Report**

The visit report will highlight examples of endocrine excellence, matters for consideration and recommendations for change. The initial report will be finalised after the networking event with similar sized centres. The report will be supportive, rather than punitive, but will highlight any

issues. Those reviewed will have an opportunity to correct any *factual* inaccuracies in a draft version of the report. The report will be confidential, and the final version will be sent to the SfE National Coordinator for Peer Review and to no other party without the express permission of the centre reviewed. Those reviewed will have the opportunity to provide feedback on the review process. The reviewers will also be asked to complete a feedback questionnaire. Following the review, those participating will have an opportunity to form part of the team for a future review visits.

**Standards**

The SfE has identified 5 standards for the shorter review, against which the peer reviewed centres will be considered. These will be judged as met, exceeded, unmet, no supporting evidence, or not applicable. This will be based on best practice or nationally agreed standards and where no guide, steered by expert opinion.

| GRADING OF ENDOCRINE STANDARD | GRADING ABBREVIATION (IN REPORT) | DEFINITION |
|---|---|---|
| **MET** | **M** | Evidence or information which shows the criterion is being met and good practice demonstrated |
| **EXCEEDED** | **Exc** | Exceptional practice and achievements |
| **UNMET** | **UnM** | Evidence or information which shows the criterion is not being met |
| **NO SUPPORTING EVIDENCE** | **N.S.E** | No supporting evidence provided by the visited endocrine unit |
| **NOT APPLICABLE** | **N/A** | Criterion not applicable to this endocrine unit |

The standards are listed below with explanatory notes.

**Standards for an Endocrine Service**

1. Specialist care should be delivered according to the principles:

    - Right people; Endocrinologists and specialist nurses involved in specialist endocrinology should have evidence of appropriate experience and training in complex endocrinology.

    - Right place and networks; multi-disciplinary teams with the appropriate collective expertise should deliver specialist care. Regional and national collaboration should be in evidence to provide expert care for complex conditions, or effective links with the specialist centres able to deliver or advise on the appropriate care.

2. Services should be efficient, innovative and responsive: there should be effective prioritisation and capacity, pre and post clinic testing where possible, enhanced referral triage, advice and guidance, pathways and protocols

3. Services should be patient centred**;** Patients should have choice of mode of appointment, a range of ways of delivering care both face to face and virtually, and options for follow up. Patents should have access to appropriate information, links to patient support groups and partnership in shared decision making.

4. Care should be safe and accountable:

    - There should be clear pathways for acute endocrine emergencies to ensure safe care for patients

    - Should be evidence of processes in place to keep patients safe as mandated by NPSA for adrenal insufficiency, cranial diabetes insipidus (AVP-D)

    - There should be evidence of clinical governance including evidence of regular audit

5. Training and research opportunities should be considered as part of routine practice to ensure the service is continuing to develop and resilient to change.

**General information about your service**

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| **Name of person / people completing form** | |
| **Position(s) held** | |
| **Date of completion** | |

| **Section 1: GENERAL INFORMATION ABOUT YOUR REGION/DISTRICT** | |
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| What is the population of your catchment area for primary care referrals? | ➢ <300 000<br>➢ 300 000 – 500 000<br>➢ 500 000<br>➢ unknown |
| Does your Region or District have any particular characteristics (social deprivation, preponderance of elderly, rural access problems, language barriers etc)? | Free text |
| Do you receive specialist endocrine referrals from outside of this area and if so, where from: | ➢ within region<br>➢ national<br>➢ other – please state |
| Do you have a catchment area for delivery of specialist care of > 1 000 000? | Yes/ No |
| Name the tertiary centre(s) for complex referrals?<br>Are there different tertiary referral centres for different conditions or complexity? If so, please specify | Free text |
| How many beds does your trust have? | <400<br>400-700<br>700-1000<br>>1000 |

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| How many individual consultants deliver clinical endocrinology care in your centre? | Numbers 1-15 and >15? Please number |
| From these, how many people also have sessions in:<br>• Diabetes<br>• General or acute medicine<br>• University Academic role<br>• University Teaching role<br>• Management Role<br>• Delivering care for those with specialist endocrinology conditions (defined by CRG)<br>• Other national roles – paid or unpaid | |
| Number of **Endocrine New Patients** seen annually in your centre (excluding nurse-led clinics). Please ask your Data Department to provide figures on your activity, ideally over the last 3 years. | |
| What pathway changes have you developed that influences new to follow up ratios?<br>What are the numbers of Advice and Guidance referrals over the last year (provide data if possible or state if estimate)? | Eg Robust A&G, pre clinic testing, Endocrine specialist nurse pathways, PIFU etc |
| Estimate what proportion of your work is specialist Endocrinology according to CRG criteria here | <10%<br>10-25%<br>25-50%<br>>50% |

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| Are there any concerns highlighted through GIRFT / GMC survey / specialty dashboard / patient surveys? | |

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| What changes or innovations are you most proud of or would be prepared to share with the wider endocrine community? | |
| What are the changes most wanted next in your unit? | |
| How would you like the endocrine unit to be developed over the next 10 years? | |
| What is your reason for participating in peer review? | |

**STANDARDS**

1. **<u>Specialist care:</u>**

Specialist care should be delivered according to the principles:

a. Right people; Endocrinologists and specialist nurses involved in specialist endocrinology should have evidence of appropriate experience and training in complex endocrinology.

***Rationale:*** *Specialist endocrinology requires experience and time dedicated to clinical practice to achieve best outcomes with regular continuing professional development (CPD) and appropriate training and experience as consultants and specialist nurses.*

- *Doctors: Continuing Professional Development (CPD) should include regular case review meetings, national and regional endocrine specific meetings, evidence of appropriate case numbers of specialist conditions, MDT involvement, job plans with significant time in endocrinology.*
- *Endocrine Specialist Nurses: They should have adequate training based on the SFE Competency Framework for Adult Endocrine Nursing. Training should include the advanced health assessment and independent non-medical prescribing for those running nurse-led clinics. Nurses should have the opportunity to develop skills in clinical, educational and research roles.*
- *Other Allied Health Professionals: Specialist pharmacists, psychologists are helpful additions to support larger endocrine services.*

**Examples of Grading to meet Endocrine Standard- Specialist Consultant Care**

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|---|---|
| **MET** | Continuing Professional Development in Endocrinology and areas of subspecialist focus.<br>Evidence of regular MDT meetings to discuss complex cases and results with evidence of recording and sharing outcomes<br>Clear integrated pathways described between specialist teams who have experience of specialist work with endocrinology such as surgery, nuclear medicine, radiology, biochemistry, anaesthetics |
| **EXCEEDED** | Highly developed MDT working with subspecialty interests appropriate for the size of centre and complexity<br>Leading MDT as 'hub', accessible to regional colleagues with evidence of documenting and sharing outcome decisions<br>Nominated Endocrine surgeons job planned to deliver numbers specified by GIRFT, with clear record of results |

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| | Highly developed joint working between teams such as endocrine and pituitary surgery, histology, cytology, clinical and medical oncology, radiology, biochemistry, paediatrics<br><br>Evidence of integration of endocrine medicine for pre- and post-op endocrine surgical patients<br><br>Nominated anaesthetists who jointly manage patients in the peri-operative period<br><br>Engagement of Consultants with Regional or National Committees delivering change eg NICE, SFE, BTA etc.- document if paid of unpaid |
| **UNMET** | Inappropriate networking or specialist MDT to support seeing specialist conditions or joint working eg radiology, biochemistry, pathology, appropriate for the size of service<br><br>No standardised recording or distribution of information from MDT<br><br>Lack of CPD specific for Endocrinology or evidence of any specialisation of interests across the specialty |
| **NO SUPPORTING EVIDENCE** | |
| **NOT APPLICABLE** | |

**Examples of Grading to meet Endocrine Standard- Nursing Care and Allied Health Professionals**

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| **MET** | Dedicated endocrine nursing service with subspecialty interests appropriate for the size of centre and complexity<br><br>Appropriate job allocation according to the ESN's banding<br><br>Appropriate and adequate training and supervision provision according to the ESN's job role, following the SFE Competency Framework<br><br>Clerical support for ESN<br><br>Nurses attending local, regional and national meetings<br><br>Easy and immediate access for consultant input for ESN<br><br>Access of ESN by phone/email/in person urgent or alternative available for patients<br><br>Nurse led audit<br><br>Appropriate supervision of all AHP and evidence of support for CPD and career progression |
| **EXCEEDED** | Enough ESN to allow appropriate sub specialisation<br><br>Highly developed training programme – in house and external for ESN training |

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| | Highly developed access phone/email or in person walk in available for patients, with audited numbers<br>In patient in reach service for all patients undergoing endocrine procedures or surgery or other inpatient review<br>Nurse led audit/research submitted as abstracts for meetings /published<br>Nurse prescribing qualification<br>Nurse engagement at national and international level (e.g. SfE Nurse Committee, ESE Nurse Committee, NICE guideline group)<br>Dedicated pharmacist for endocrinology<br>Access for psychology for endocrine patients |
| **UNMET** | No ESN<br>No or limited access of ESN to training<br>No clerical support for ESN<br>No immediate access for consultant input for ESN<br>No access phone/email/in person walk in available for patients<br>No in patient in reach service as needed<br>No nurse led audit |
| **NO SUPPORTING EVIDENCE** | |
| **NOT APPLICABLE** | |

| **SAQ** | **Discussion point** |
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| How is specialist and general endocrine work (according to CRG criteria) shared in the department?<br>Are there any subspecialty clinics? | Free text |
| Do all consultants delivering specialist endocrinology keep abreast of developments in Endocrinology by attending local, regional and/or BES, or International meetings on an annual basis? | |

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| How many WTE specialist nurses are there in the endocrine department?<br>Are any of these jobs not exclusively endocrine (eg combined with diabetes)?<br>If you do not currently have an endocrine specialist nurse, has a business case previously been rejected? | |

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| What are the WTE for each of the ESN bandings? | Band 4<br>Band 5,6,7,8 |
| Is there a Personal Development Plan in place including?<br>• SFE Competency Framework for Adult Endocrine Nursing<br>• advanced health assessment,<br>• independent non-medical prescribing<br>• post-graduate courses (e.g. Masters-level courses).<br>• Protected study time<br>• Protected time for MDTs, appropriate academic and professional meetings, networks and observe peers.<br>• Line management (see below) | Yes/No |
| Does an ESN carry out?<br>a. Endocrine investigations, test and treatment;<br>b. out-patient nurse led clinics<br>c. virtual clinics<br>d. pre/post-operative care/support.<br>e. In-patient care<br>f. Patient education (e.g. individual or group)<br>g. Staff education?<br>Please describe what oversight there is of these services if not done by ESN directly. | Yes/NO<br><br>Free text |
| *Of the ESN roles described above, which would you consider as the most critical part of the ESN role (role that your service can not do without if staff redeployment is to happen again in the future).*<br>*Are there valuable innovations to be shared?* | |
| In the last 5 years how many audits / case presentations / posters at conferences / talks have the ESNs in total contributed to? | |
| *Have ESN been responsible for service redesign? Please give examples in the last 5 years.*<br>If there were availability / further expansion of the endocrine nurse service, what would be the priority for development? | |

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| Is there appropriate clerical support for ESN? | Yes/no |
| Are there any additional allied health professionals attached to your endocrine service such as a psychologist, pharmacist, physician's assistant etc?<br>*How have they enhanced care or relieved roles from other professionals?* | |

b. Right place and networks; multi-disciplinary teams (MDT) with the appropriate collective expertise should deliver specialist care. Regional and national collaboration should be in evidence to provide expert care for complex conditions, or effective links with the specialist centres able to deliver or advise on the appropriate care.

***Rationale:*** *Specialist endocrinology requires regular involvement in MDTs that deliver pituitary, adrenal, neuroendocrine, thyroid, reproductive, bone care. It involves close collaboration with specialist services such as biochemistry, pathology and radiology with subspecialty interests in endocrinology. MDTs should fit the CRG and GIRFT recommendations here for core membership. Regular opportunity to discuss complex cases should be available at a local and regional level to deliver care rapidly at a population level suitable for complexity. Networks to collaborate for complex investigations such as venous sampling, ablations etc should be evidenced and outcomes / audits available.*

**Examples of Grading to meet Endocrine Standard - MDT working**

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| **MET** | MDT attendance quorate with doctors who know the patients presenting cases<br>MDT for adrenal/thyroid/pituitary<br>Regular access to, or running of networked specialist MDTs<br>If running MDT, evidence of ease of access and timely outcomes communicated to those making referral<br>MDT outcomes communicated to relevant clinicians and patients promptly<br>Regional meetings with other Trusts to discuss cases and educational aspects of endocrinology |
| **EXCEEDED** | All clinics scheduled with pre or post clinic meetings to discuss cases<br>MDT efficiency with clear level of complexity needing a team discussion |

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| | ENETS CoE<br>Specialised clinics for Turner patients<br>Reproductive medicine clinics<br>Metabolic bone<br>Specialised genetic clinics<br>Dedicated transition service<br>Dedicated Graves ophthalmopathy clinic<br>Dedicated late effects service<br>Other specialist services |
| **UNMET** | No regular access to, or running of networked specialist MDTs<br>If running MDT, little evidence of ease of access and lack of timely outcomes communicated to those making referral, inefficient processes for discussion |
| **NO SUPPORTING EVIDENCE** | |
| **NOT APPLICABLE** | |

| **Standard 1b** | |
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| How are complex clinical cases discussed? Eg clinical case meeting? If so, how frequently and what are the main objectives? | |
| List joint clinics with other departments | Free text |
| Are there MDTs based in your hospital in the following:<br>Adrenal<br>Thyroid<br>Pituitary<br>NET<br>Reproductive<br>Metabolic bone<br>Late effects<br>other<br>*If not, please describe referral pathway arrangements to for complex cases.* | Y/N |

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| Are there any of the MDTs which do not routinely have core members present (as defined by the CRG /NICE or agreed NHSE/I metrics recommendations)?<br>How are these meetings appropriately minuted?<br>Are they supported by coordinators? | |
| If asking for advice from outside your specialty and centre, how do you access this and any problems with a quick and considered response? | |
| *What could be done more efficiently in MDTs?*<br>*Please share learning points.* | |
| In your trust what are the number of consultant-level Surgeons specialising in:<br>i) thyroid and parathyroid (20+20);<br>ii) adrenal (6 + 20);<br>iii) HPB surgery<br>iv) Pituitary (20)<br>v) Bariatric surgery<br>Do they meet minimum numbers recommended by GIRFT (as above)?<br>*Any issues with an integrated endocrine surgical pathway?*<br>*Are there any out of trust referrals (or referring in from other trusts)?* | |

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| Is there a network (regular collaboration) across the region of endocrinologists and if so, what type / purpose/how often meet? Is there a record of attendance and minutes? | |
| What other specialist or super specialist services are available:<br>Endocrine transition<br>Graves eye network<br>Turner syndrome<br>T3 or T4 weight management service<br>Infertility and fertility preservation<br>Gender services<br>Genetics<br>Late effects | |

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| Endo oncology<br>NET<br>Other – please specify<br><br>*Are there any services that you feel need to be developed further or you don't have easy access to through your network?* | |

## 2. Efficient, innovative and responsive services:

Services should be efficient, innovative and responsive, there should be effective prioritisation and capacity, pre and post clinic testing where possible, enhanced referral triage, advice and guidance, pathways and protocols.

**Rationale:** *Endocrine services need to be efficient and responsive with appropriate advice and guidance, pre-clinic testing, protocols and discharge support.*

a. *Advice and guidance via email and phone for primary care should be rapid and extensive, using evidence-based protocols for ongoing care. Advice should be recordable. Considering a 'population-based approach' for delivery of care.*
b. *Waiting times should ensure that urgent referrals can be reviewed within 2 weeks.*
c. *Secondary care should consider a Referral Assessment System rather than directly bookable clinic appointments to make use of 'straight to test' and pre-clinic testing options are utilised where possible.*
d. *Specialist endocrine investigations should be conducted in units that are competent to carry out the tests as defined by the Society's competency framework.*
e. *A senior endocrine opinion should be involved in every complex case of specialist endocrinology.*
f. *Prompt transfer of information to the primary referrer, GP and patient is essential, meeting local trust requirements.*
g. *Clear individual treatment plans should be initiated with appropriate and agreed responsibilities for primary care, patients, and specialist nurses.*
h. *Appropriate follow up options should include PIFU, endocrine nurse follow up.*

i. *Discharge from endocrine clinics should include clear guidance for follow up including criteria for re-referral.*

**Examples of Grading to meet Endocrine Standard- Efficient Services**

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| **MET** | Dedicated consultant oversight of telephone or e-mail A&G service exists daily (Mon- Friday)<br>Prompt response time to A&G according to trust metrics which is appropriately job planned<br>A&G advice recorded in clinical records<br>Immediate escalation pathways for endocrine emergencies (same day review on day unit or SDEC)<br>Senior endocrine triage of all referrals and urgent new patients seen within 4 weeks, urgent follow-up patients within 6 weeks<br>Effective 2 week wait pathway for suspected malignancy<br>Pre-clinic testing utilised for the majority of patients from referral triage or from A&G according to local agreed pathways<br>Use of standardised endocrine nursing pathways for endocrine conditions eg adrenal adenomas where possible<br>Availability of dedicated endocrine day unit or space for specialist investigations and assessment<br>All new patient investigations who are referred to day unit for tests should be seen within 6 weeks (urgent cases have tests within 2 weeks)<br>Dedicated patient information access by phone, email or patient portal 5 days per week, with response time typically within 48 hours<br>Availability of patient-initiated follow-up pathways |
| **EXCEEDED** | Dedicated consultant delivered telephone or e-mail A&G service exists 7 days per week<br>Less than 48 hour response time to written A&G (except weekends)<br>A&G can be directly converted to clinic appointments as required<br>Evidence of endocrine team service prioritisation (triaging) based on clinical need<br>Urgent new patients seen within less than 2 weeks<br>Routine follow ups able to be seen within the desired time window<br>Pre-clinic testing used for the majority of patients from referral triage or from A&G commented elsewhere<br>Use of standardised endocrine nursing pathways for many endocrine conditions with evidence of subspecialisation |

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| | Dedicated well-equipped endocrine day unit with well-trained endocrine specialist team for investigations and assessment, with capacity to see routine patients without significant delay.<br>Dedicated endocrine nurse advice line for patients. |
| **UNMET** | A&G: Not met majority of above criteria<br>Referrals: Not met majority of above criteria<br>Investigations: Not met the majority of above criteria<br>Patient advice not easily accessible. |
| **NO SUPPORTING EVIDENCE** | |
| **NOT APPLICABLE** | |

| **Standard 2** | |
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| How is outpatient advice delivered to primary care or other specialists? | Please tick all that apply:<br>Dedicated consultant phone line 9-5pm<br>Set time window for phone advice eg 1hr per day for consultant phone line<br>Advice only by SPR by switch<br>Email<br>Phone to admin team<br>Other: please specify |
| For formal advice and guidance, what system is used and how is this recorded in the notes? | |
| Can formal advice and guidance be converted to a referral (if permission from primary care)? | |
| How much time in job plan is assigned to advice and guidance? | |
| Please give an estimate (or data if available) about what proportion of advice and guidance referrals enter the following routes:<br>1) letter back to GP, no clinic appointment<br>2) Urgent endo clinic<br>3) routine endo clinic with decision guiding pre-tests<br>4) routine endo clinic without pre-tests | |

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| 5) tests arranged and then decision made about an appointment (eg cannulated prolactin, SST) re clinic<br>6) referred on to another service | |
| Roughly what % referrals are internal vs from primary care vs internal outside region? | Internal from hospital<br>Primary care catchment<br>Outside hospital catchment<br>Outside regional catchment |
| Which of the following services do you offer?<br>• A&G with advice on diagnosis, management and follow up.<br>• Pre-clinic testing at hospital / hospital organised testing<br>• Pre-clinic testing / filled proformas from primary care / community<br>• Endocrine Specialist nurse pathways<br>• Supported discharge protocols for primary care<br>• Patient initiated follow up (with appropriately ring-fenced time slots for early review) | Y/N, then rough % routed to this pathway |
| What strategies are in place to see same day emergencies to avoid admission (either in the department or admitting centre)? | No capacity same day<br>No capacity same week<br>Day endocrine ward for urgent review<br>SDEC gen med for urgent review with in-reach from specialty 9-5<br>Other: please specify |
| Is there available capacity to see urgent new patients within 2W and urgent follow up appointments within 6W?<br><br>Are there dedicated slots for urgent patients? Y/N | |

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| Is there sufficient appointment capacity to see patients in a timely fashion as dictated by clinical need?<br>What are the barriers to this? | Y/N<br><br>Medical Workforce<br>Specialist Nurse Workforce<br>Clinic space<br>Lack of time to appropriately virtually manage results and advice and guidance<br>Recurrent cancellations due to GIM commitments.<br>Other: please specify |
| Roughly what % of new patients are seen:<br>F2f<br>Video<br>Phone | |
| Roughly what % of follow up patients are seen:<br>F2f<br>Video<br>Phone | |
| Are there any room capacity or other issues that mean that you can't accommodate face to face? | |
| What % of new patients are seen or has management plan agreed with a consultant? | |
| Where are endocrine dynamic day case tests carried out? | Endocrine dedicated beds/units staffed by ESN<br>Hospital day unit staffed / supervised directly by ESN?<br>Hospital day unit staffed by daycase staff?<br>Other – please specify? |
| Are there any particular delays in parts of the treatment pathway from referral to final treatment? | Y/N please specify problem |
| What options are there for patients contacting for urgent advice or appointment? | |

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| ESN phone<br>email advice<br>Walk in service<br>Urgent follow up appts<br>ESN FU clinics?<br>PIFU?<br>Patient portal<br>Other – please specify? | |
| Is there adequate support for doctors and ESN in the following:<br>Admin support<br>office space<br>space for virtual clinics that provides privacy<br>Working From Home<br>Other? | Y/N free text explanation |

3. **<u>Patient-centred Services:</u>**

Services should be patient centred**;** Patients should have choice of mode of appointment, have access to appropriate information and partnership in decision making where appropriate.

***Rationale:*** *Patients should have choice about how care is delivered (when clinically appropriate) with options of face to face, video, phone or email / patient portal correspondence. Patients with 'specialist endocrinology' conditions should ideally have access to a specialist endocrine nurse with an advice line. There should be easily available disease specific information clearly directed to patients, including appropriate signposting to patient support groups. Patients should be involved in decision making for treatment options and have access to results (through patient portal if available). Where appropriate patients should have choice about follow up, including patient-initiated follow-up (PIFU) options.*

**Examples of Grading to meet Endocrine Standard -Patient-centered service**

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| **MET** | Patient are given option for their preferred consultation (face-to-face, telephone, video) when appropriate and PIFU available<br>Facility for changing appointment is easily available to patient (telephone or online request platform).<br>Patient has access to their medical records including test results and clinic letters online.<br>System in place for appointment reminder<br>Patients are clearly signposted to ESN help lines for advice. |
| **EXCEEDED** | Online facility for changing and requesting appointment is widely used across the service.<br>Patient Portal for communication between health care and patient<br>System in place for join consultations if other specialists need to be involved<br>An attempt to contact all patients by phone if not attended their preferred mode of appointment (to minimise DNA and recognise inequality of access)<br>Evidence of advocacy for patients outside of clinic appointments eg when admitted for urgent care |
| **UNMET** | No evidence of ESN involvement<br>No evidence of access to patient support groups or online / paper copies of disease specific information |
| **NO SUPPORTING EVIDENCE** | |
| **NOT APPLICABLE** | |

| **Standard 3** | |
|---|---|
| Do patients have choice for contact (**if clinically appropriate**) in the following ways:<br>F2F or virtual (TC, VC)<br>Urgent Phone advice (doctor or nurse)<br>Email or patient portal on EPR (doctor or nurse)<br>PIFU follow up<br>What hours is urgent advice available? | **Y/N** |
| *How are these services advertised to patients?*<br>*What barriers are there to these services?* | |

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| Are the following available from the first appointment to help patients find more information about their condition:<br>1. Paper copies /electronic of disease specific information?<br>2. Different language options for patient info sheets?<br>3. Web links to patient information groups?<br>4. Own departmental webpage link<br>5. Information attached to clinic letters<br>6. Posters advertising patient info groups?<br>Do these links form part of routine letters /appointments? | Y/N |
| Do you offer any community support, population education or patient group events in endocrinology? | Free text |
| Have you got any Patient reported Outcome Measures (PROMS) or Patient Reported Experience Measures (PREMS) to measure outcomes in long term conditions (LTC)? | Y/N<br>Free text |
| What local initiatives are in place to reduce inequality: eg patient advocates,<br>Travel costs,<br>Charitable funds for accommodation if needed.<br>Policy for DNA that recognises inequality?<br>Choice of clinic times?<br>Clinic times outside working hours? | |

## 4. Accountable Services:

Care should be safe and accountable:

- There should be clear pathways for acute endocrine emergencies to ensure safe care for patients
- Should be evidence of processes in place to keep patients safe as mandated by NPSA for adrenal insufficiency, cranial diabetes insipidus (AVP-D)

- There should be evidence of clinical governance including evidence of regular audit

***Suggested standard statement rationale:*** *Patient safety during pre-hospital care, inpatient stays, post-discharge and follow-up should be considered for the key areas of endocrinology such as adrenal insufficiency, diabetes insipidus, pheochromocytoma with clear mechanisms in place to protect patients, particularly when not under an endocrinologists' care. Evidence of endocrine governance and active audit is an essential part of good care. All patients, should have accurate coding, or a consented database, that would allow regular audit. A Good practice would include consideration to a green agenda for delivery of care.*

**Examples of Grading to meet Endocrine Standard - Safe, Innovative and accountable**

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| **MET** | Evidence that all endocrine emergencies are cared for by the endocrine team when it is their primary admitting complaint.<br>Evidence of involvement of the endocrine team when patients with complex endocrine conditions are admitted for an unrelated condition.<br>Evidence of alert system in ED, ambulance services for adrenal insufficiency and cranial diabetes insipidus (Arginine Vasopressin Deficiency)<br>Dedicated routine endocrinology in-reach service 5 days per week<br>Regular specialty specific endocrinology quality/clinical governance meetings (not part of general medicine) and morbidity and mortality with evidence of minutes and actions.<br>Evidence of endocrinology audit programme<br>Accurate coding of activity (inpatient, day case testing and outpatient)<br>Evidence of steroid emergency cards routinely given to patients with adrenal insufficiency of all causes |
| **EXCEEDED** | 7-day endocrine opinion available for emergencies.<br>Dedicated endocrine nursing support for inpatient education<br>Endocrine audits, at least 5 in the last two years.<br>Evidence of publication / presentation of local results from audits and audit loops / change to region or national<br>SOPs/guidelines for ALL common endocrine emergencies |

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| | Alert systems in community, ED and ambulance services for conditions such as adrenal insufficiency<br>Publication of local audit results at national and international conferences<br>Systematic review of endocrine readmissions<br>Evidence of urgent care education for other urgent conditions besides Addison's disease, eg. pheochromocytoma and diabetes insipidus, turner dissection in pregnancy. |
| **UNMET** | Does not meet the majority (<50%) of met criteria<br>No evidence of meeting NPSA standards |
| **NO SUPPORTING EVIDENCE** | |
| **NOT APPLICABLE** | |

| **Standard 4** | |
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| Do you have a way of alerting out of hours services eg primary care, ambulance services, ED) to ensure appropriate emergency treatment for adrenal crisis?<br>Do you routinely give out emergency information or cards to patients for other urgent conditions eg phaeochromocytoma, diabetes insipidus (AVP-D), pregnant patient with Turner syndrome. | |
| If you have endocrine beds are emergency admissions of complex endocrine patients routinely referred to the endocrine team, even if not principally under their care?<br>Is there a 7 day endocrine opinion available?<br>Is there an in-reach service in endocrinology? Describe it. | Most of time / some of the time / rarely / never<br>Y/N<br>Y/N<br>Free text |
| How are endocrine incidents reported, communicated, actioned and monitored? Is there a regular departmental morbidity and mortality and governance meeting? | Free text |
| Are there any problems organising inpatient investigations (inpatient fasts) and treatments (eg RAI) performed? | Free text |
| What endocrine audits have been carried out in last 5 years?<br>What proposed audits are there for next 5 years? | |
| Does your endocrine coding give an accurate reflection of your activity in the following: | |

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| Inpatient specialist admissions<br><br>Outpatient day case admissions (particularly in reference to outpatient tests?<br><br>If not, what methods are used to find patients for audit / research or correct coding? | |
| Has your trust green/sustainability strategy been applied within your service? Give examples. | |

**5. <u>Training and research:</u>**

Training and research opportunities should be considered as part of routine practice to ensure the service is continuing to develop and resilient to change.

***Suggested standard statement rationale:*** *There should be appropriate training and development opportunities for undergraduate and postgraduates, specialist nurses and non-specialists (primary, secondary care) to future proof the service. Consultant time for pre and post clinic discussions needs to be included in job plans. Training needs to take account of new ways of working, with protected time in specialty with consultant presence in clinics, but also opportunities for trainees to participate in networked MDTs, doing advice and guidance, research and quality improvement. Clinical research opportunities need to be embedded in day-to-day care.*

**Examples of Grading to meet Endocrine Standard - Training and Research**

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| **MET** | Evidence of clinic experience for undifferentiated trainees and medical students<br><br>Specialist Trainees (ST) see wide range of patients with post / pre clinic meeting<br><br>General Internal Medicine rota commitments do not significantly impact on speciality training experience<br><br>Specialist Trainee able to attend and present at endocrine conferences<br><br>Previous training concerns specific for endocrinology in the process of being addressed<br><br>Consultant job plans with allocated time for supervision and clinical case discussion<br><br>Research output meets that expected for size of department |
| **EXCEEDED** | No ST time off GIM rota but |

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| | Undifferentiated trainees attending clinic with chance to see patients on their own followed by consultant review and WPBA.<br><br>IMT3 trainees having own clinic lists and regular attendance.<br><br>Specialist Trainees see wide range of patients with pre/post clinic meeting and chance to present at weekly departmental meeting<br><br>Protected time away from General Internal rota for specialist trainees as part of their rotation<br><br>Evidence of trainees being able to network and attend regional networks and MDTs throughout their training, even if not principally in the hospital.<br><br>All departmental team including doctors in training across all grades chance to attend conferences, submit abstracts and have oral / poster presentations<br><br>Previous training concerns specific for endocrinology addressed and evidence the problems have been rectified<br><br>Consultant job plans include sufficient time for supervision and training including departmental meeting<br><br>Research output exceeds that would be expected for size of department with original publications<br><br>Number of trainees with or registered for a higher degree (MD/PhD) greater than national average.<br><br>Current NIHR Lectureships in Endocrinology/Diabetes |
| **UNMET** | Minimal or no IMT or undifferentiated trainees attendance at clinic<br><br>Lack of pre/post-clinic meeting or review of patients seen by SPR<br><br>Burden of General Internal Medicine commitments and general medical ward commitments limits speciality training experience for registrars<br><br>Minimal or no IMT/SPR attendance at conferences or abstract / poster presentations at endocrine conferences<br><br>Training concerns specific for endocrinology previously raised (e.g. in GMC survey) not addressed<br><br>Consultant job plans - minimal time for supervision / training<br><br>Minimal research output that would be expected for size of department |
| **NO SUPPORTING EVIDENCE** | |
| **NOT APPLICABLE** | |

| **Standard 5** | |
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| How many of the following are assigned to an endocrine (or diabetes) firm in your department: | |

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| IMT3<br>SPR<br>Academic SPRs | |
| Estimate what proportion of consultant clinics regularly have associated:<br>• Specialist registrars<br>• Undifferentiated trainees or IMS2 trainees<br>• Medical Students | <20,<br>20-50%,<br>50-75%,<br>>75% |
| Are any clinics regularly held by specialist trainees in the absence of a consultant? If so, what arrangements are in place to discuss patients? | Ad hoc, set meetings per week, post clinic meetings, only if necessary? |
| Do specialist trainees have any protected periods of specialty training from general internal medicine (GIM) in your trust when:<br>• Not covering general medical ward work?<br>• Not covering acute unselected take?<br>How is this achieved? | Yes period of complete protection, period of partial protection (evenings only), no protection. |
| If not having a period of protected time, is this achieved elsewhere on the rotation? | Y/N/ don't know |
| How many endocrine clinics (or equivalent learning opportunities) are specialist trainees able to achieve a week (average) during:<br>• Completely protected time from GIM<br>• Partially protected time (reduced commitment to wards / GIM rota)<br>• No protected time | |
| How often in the last year have a member of the department (consultant, ESN or SPR) been redeployed to cover additional general or acute internal medicine shifts with disruption to specialty work?<br><br>Are there opportunities to make up missed learning opportunities? Please describe. | Rarely?<br>Every month?<br>Every week?<br>Other – please specify. |
| Are there regular (at least monthly) opportunities for SPRs to attend or participate in the following:<br>• Specialist clinics | |

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| • Specialist MDTs in trust or regional<br>• Study leave<br>• Case presentations, research papers or presentations at conferences<br>• Regular registrar regional teaching<br>• Regular pre and / or post clinic discussions<br>If not, what are the issues or alternatives provided? | |
| Are there appropriate clinic opportunities for undifferentiated trainees (including IMT3) and IMS2 trainees to attend general clinics?<br>If not, what are the hurdles? | |

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| Do consultants have any allowances in job plans or in clinic numbers to supervise in clinics or other training opportunities? | |
| How many publications and regional / national conference abstracts have been submitted by the department in the last 3 years in Endocrinology and separately in Diabetes? | |

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| Is the unit active in research?<br>If so, please provide the unit research summary<br>If not, what are the barriers to this? | |

| **Final comments** | |
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| What are your top 5 priorities to improve your service? | |
| Is there anything that you particularly wanted to highlight in your review or spend time discussing with other centres? | |

Appendices (for reference only) here